

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

ED MAY 18 1943

State File No. _____

Registration District No. **318**

Primary Registration District No. **1003**

Registrar's No. **4314**

1. PLACE OF DEATH:

(a) County _____
(b) City or town **St. Louis, Missouri**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
Homer G. Phillips Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **8 days** (Specify whether
In this community **17 years** (Specify whether
years, months or days)

3. (a) PRINT FULL NAME **Raymond Davis**

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex **Male** 5. Color or race **Col** 6. (a) Single, widowed, married, divorced **SINGLE**

6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased **Nov 28 - 1913**
(Month) (Day) (Year)

8. AGE: Years **19** Months **5** Days **7** If less than one day _____ min.

9. Birthplace **Ocala, Ark**
(City, town, or county) (State or foreign country)

10. Usual occupation **laborer**

11. Industry or business **Tobacco Co**

12. Name **Jeff Davis**

13. Birthplace **Texarkana, Ark**
(City, town, or county) (State or foreign country)

14. Maiden name **Blayden Benson**

15. Birthplace **Carson, Ark**
(City, town, or county) (State or foreign country)

16. (a) Informant **Conrad Austin**

(b) Address **3304 Loclede**

17. (a) **Burial** (b) Date thereof **MAY 10 - 43**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Pathy Dickson**

18. (a) Signature of funeral director **John Beale**

(b) Address **2726 Lucas Ave**

19. (a) **MAY 10 1943** (b) Registrar's signature **J. F. Bruesch**
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **06-1**
(c) City or town **St. Louis** (If outside city or town limits, write "RURAL")
(d) Street No. **3304 Loclede** (If rural, give location)
(e) Citizen of foreign country? **0** (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **May** day **5**,
year **1943** hour **4** minute **15 P.** M.

21. I hereby certify that I attended the deceased from **April 27**, 19**43** to **May 5**, 19**43**;
that I last saw him alive on **May 5**, 19**43**;
and that death occurred on the date and hour stated above.

Immediate cause of death: **Hypertension; Chr. Nephritis**
Acute Bilateral Otitis Media Suppurativa
Due to _____
Duration **Unk.**

Due to _____
Other conditions: **12/1**
(Include pregnancy within 3 months of death)

Major findings: _____
Of operations _____
Of autopsy _____
PHYSICIAN _____
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify) _____
(b) Date of occurrence _____
(c) Where did injury occur? _____ (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

While at work? _____ (Specify type of place) (e) Means of injury _____

23. Signature **J. F. Bruesch** (M. D. or other) _____
Address **2601 N. Whittier** Date signed _____

MOTHER FATHER

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....
....., Registered Apprentice No.....
working under my personal supervision.

Signed.....

Arthur L. Hellard

Licensed Embalmer No. *4221*

P. O. Address *4219^a Garfield*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.